CUBICIN (Daptomycin)

MEDICAL NECESSITY INFORMATION SHEET

Prescriptions must be written by or at the request of a designated specialist listed below under "Specialty of Physician Consultant."

Date: _____

Patient's Name: _____ Date of Birth:_____

Patient 9 Digit IDPA No. _____

Is This a Renewal Request? [ ] Yes [ ] No

Was Cubicin Started in the Hospital? [ ] Yes [ ] No

Culture Report: _____ Location of Infection: _____

Requested Dose: _____ Length of Therapy: _____

Physician Consultant's Name: _____

State License _____ Office Tel: _____

Specialty Of Physician Consultant: [ ] Infectious Disease [ ] Hematology/Oncology
[ ] Critical Care [ ] Surgery (All Fields)
[ ] Nephrology

Prescribing Physician's Name (If Not Consultant): _____

State License #_____ Office Telephone.#_____

Pharmacy Name: _____ Tele.#_____

ALL REQUESTED INFORMATION MUST BE SUBMITTED OR APPROVAL WILL NOT BE GRANTED.

Fax to 217-524-7264 Attn: Medical Committee

All Information Is Confidential And To Be Used Only By IDPA Personnel Involved In The Prior Approval Process

Revised 03/17/03